FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022418

Facility Name: REGENCY HLTHCARE & REHAB CTR

Address: 6631 N MILWAUKEE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 647-7444 **Fax #** (847) 588-1330

IDPA ID Number: 362871301002

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY C. BUXBAUM, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,513	5,352	7,562	24,427	8
9	SNF/PED					9
10	ICF	38,489	26,724		65,213	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,002	32,076	7,562	89,640	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.86%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/30/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/30/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 7302

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	404,343	62,876	25,146	492,365		492,365		492,365			1
2	Food Purchase		409,406		409,406	(48,545)	360,861	(1,459)	359,402			2
3	Housekeeping	291,036	35,822	217	327,075		327,075		327,075			3
4	Laundry	117,759	44,483	450	162,692		162,692		162,692			4
5	Heat and Other Utilities			240,249	240,249		240,249	1,794	242,043			5
6	Maintenance	93,183	18,565	92,352	204,100		204,100	1,314	205,414			6
7	Other (specify):*											7
8	**TOTAL General Services**	906,321	571,152	358,414	1,835,887	(48,545)	1,787,342	1,649	1,788,991			8
	B. Health Care and Programs											
9	Medical Director			50,600	50,600		50,600		50,600			9
10	Nursing and Medical Records	3,246,868	99,181	244,734	3,590,783		3,590,783		3,590,783			10
10a	Therapy	72,263	5,421	6,624	84,308		84,308	3,563	87,871			10a
11	Activities	164,338	8,033	2,524	174,895		174,895		174,895			11
12	Social Services	102,830		4,800	107,630		107,630		107,630			12
13	Nurse Aide Training											13
14	Program Transportation							185	185			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,586,299	112,635	309,282	4,008,216		4,008,216	3,748	4,011,964			16
	C. General Administration											
17	Administrative	175,400		642,281	817,681		817,681	(212,450)	605,231			17
18	Directors Fees											18
19	Professional Services			155,971	155,971		155,971	(3,480)	152,491			19
20	Dues, Fees, Subscriptions & Promotions			170,847	170,847		170,847	(124,443)	46,404			20
21	Clerical & General Office Expenses	302,258	66,778	110,876	479,912		479,912	(76,255)	403,657			21
22	Employee Benefits & Payroll Taxes			1,026,638	1,026,638	48,545	1,075,183		1,075,183			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,784	2,784		2,784		2,784			24
25	Other Admin. Staff Transportation			1,652	1,652		1,652		1,652			25
26	Insurance-Prop.Liab.Malpractice			134,544	134,544		134,544	846	135,390			26
27	Other (specify):*							17,046	17,046			27
28	**TOTAL General Administration**	477,658	66,778	2,245,593	2,790,029	48,545	2,838,574	(398,736)	2,439,838			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,970,278	750,565	2,913,289	8,634,132		8,634,132	(393,339)	8,240,793			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR #0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			133,708	133,708		133,708	189,473	323,181			30
31	Amortization of Pre-Op. & Org.			10,704	10,704		10,704	(10,704)				31
32	Interest			144,424	144,424		144,424	409,406	553,830			32
33	Real Estate Taxes			399,231	399,231		399,231	(28,753)	370,478			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,080,000)				34
35	Rent-Equipment & Vehicles			18,774	18,774		18,774		18,774			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,786,841	1,786,841		1,786,841	(520,578)	1,266,263			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	132,945	310,377	79,749	523,071		523,071	11,412	534,483			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	46,075			46,075		46,075	(45,575)	500			43
44	**TOTAL Special Cost Centers**	179,020	310,377	243,999	733,396		733,396	(34,163)	699,233			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,149,298	1,060,942	4,944,129	11,154,369		11,154,369	(948,080)	10,206,289			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	48,143	30		9
10	Interest and Other Investment Income	(38,079)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,459)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,747)	21		24
25	Fund Raising, Advertising and Promotional	(46,899)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(20,713)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(72,932)	20		28
29	Other-Attach Schedule	(143,323)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (328,009)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(620,071)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (620,071)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (948,080)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

REGENCY HLTHCARE & REHAB CTR

ID# 0022418

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Depreciation	$ (1,775)	30	1
2	Charitable Contributions	(364)	20	2
3	Misc Income	(78)	21	3
4	Promotional Salary	(45,575)	43	4
5	Regency At Home Care - Interest Expense	(6,372)	32	5
6	Non Allow Related Party Interest	(18,531)	32	6
7	Political Contribution - (COPE)	(4,701)	20	7
8	Amort. Of Loan Acquisition Cost	(10,704)	31	8
9	Bank Charges	(3,863)	21	9
10	Collection Service	(2,423)	19	10
11	Regency At Home Health - Interest Expense	(1,890)	32	11
12	Web Site Design	(6,500)	19	12
13	Capitalized Architect Fees	(863)	06	13
14	1998 R/E TAX REFUND	(39,685)	33	14
15				15
16				16
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,459)											(1,459)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			795		999							1,794	5
6	Maintenance	(863)		930		1,246							1,314	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,321)		1,725		2,245							1,649	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy					3,563							3,563	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation					185							185	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**					3,748							3,748	16
	C. General Administration													
17	Administrative				(212,450)								(212,450)	17
18	Directors Fees													18
19	Professional Services	(8,923)		250	2,431	2,762							(3,480)	19
20	Fees, Subscriptions & Promotions	(124,896)		46	29	378							(124,443)	20
21	Clerical & General Office Expenses	(77,401)		93	506	547							(76,255)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			375		471							846	26
27	Other (specify):*				17,046								17,046	27
28	**TOTAL General Administration**	(211,220)		764	(192,438)	4,158							(398,736)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(213,541)		2,489	(192,438)	10,151							(393,339)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	46,368	134,359	4,144		4,602							189,473	30
31	Amortization of Pre-Op. & Org.	(10,704)											(10,704)	31
32	Interest	(64,872)	450,977	4,770		18,531							409,406	32
33	Real Estate Taxes	(39,685)		4,846		6,086							(28,753)	33
34	Rent-Facility & Grounds		(1,032,000)	(48,000)									(1,080,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(68,893)	(446,664)	(34,240)		29,219							(520,578)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					11,412							11,412	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(45,575)											(45,575)	43
44	**TOTAL Special Cost Centers**	(45,575)				11,412							(34,163)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(328,009)	(446,664)	(31,751)	(192,438)	50,782							(948,080)	45

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
KENNETH NIEMAN	33.34%	NONE		REGENCY MGMT	NILES	MGMT CO
BENJAMIN ROGOW	33.33%	NONE		KNR PARTNERSHIP	NILES	BUILDING CO
LOTHER KAHN	33.33%	NONE		REGENCY REHAB	NILES	THERAPY CO
				REGENCY BUILDIN	NILES	BUILDING CO

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,032,000	Regency Building	100.00%	$	$ (1,032,000)	1
2	V	30	Depreciation		Regency Building	100.00%	134,359	134,359	2
3	V	32	Interest		Regency Building	100.00%	450,977	450,977	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,032,000			$ 585,336	$ * (446,664)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	KNR PARTNERSHIP	100.00%	$ 795	$ 795	15
16	V	6	REPAIRS AND MAINT.		KNR PARTNERSHIP		930	930	16
17	V	19	PROFESSIONAL FEES		KNR PARTNERSHIP		250	250	17
18	V	20	DUES AND SUBS.		KNR PARTNERSHIP		46	46	18
19	V	21	CLERICAL		KNR PARTNERSHIP		93	93	19
20	V	26	INSURANCE		KNR PARTNERSHIP		375	375	20
21	V	30	DEPRECIATION		KNR PARTNERSHIP		3,264	3,264	21
22	V	32	INTEREST EXPENSE		KNR PARTNERSHIP		4,770	4,770	22
23	V	33	REAL ESTATE TAXES		KNR PARTNERSHIP		4,846	4,846	23
24	V	33	R. ESTATE TAX-PROTEST FEES		KNR PARTNERSHIP				24
25	V								25
26	V	34	RENT	48,000	KNR PARTNERSHIP			(48,000)	26
27	V								27
28	V								28
29	V	30	DEPRECIATION		KNR PARTNERSHIP		880	880	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 48,000			$ 16,249	$ * (31,751)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	REGECY MANAGEMENT CORP.	100.00%	$ 2,431	$ 2,431	15
16	V	20	DUES, SUBSCRIPTIONS		REGECY MANAGEMENT CORP.		29	29	16
17	V	21	CLERICAL AND GENERAL		REGECY MANAGEMENT CORP.		506	506	17
18	V								18
19	V	17	MANAGEMENT FEES	642,281	REGECY MANAGEMENT CORP.			(642,281)	19
20	V								20
21	V								21
22	V	17	ADMINISTRATIVE		REGECY MANAGEMENT CORP.		158,625	158,625	22
23	V	27	EMPLOYEE BENEFITS		REGECY MANAGEMENT CORP.		6,291	6,291	23
24	V								24
25	V	17	ADMINISTRATIVE		REGECY MANAGEMENT CORP.		144,643	144,643	25
26	V	27	EMPLOYEE BENEFITS		REGECY MANAGEMENT CORP.		5,736	5,736	26
27	V								27
28	V	17	ADMINISTRATIVE		REGECY MANAGEMENT CORP.		126,563	126,563	28
29	V	27	EMPLOYEE BENEFITS		REGECY MANAGEMENT CORP.		5,019	5,019	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 642,281			$ 449,843	$ * (192,438)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	REGENCY REHABILITATION SERVICES, INC.	100.00%	$ 999	$ 999	15
16	V	6	REPAIRS AND MAINT.		REGENCY REHABILITATION SERVICES, INC.		1,246	1,246	16
17	V	10a	THERAPY CONSULTANTS		REGENCY REHABILITATION SERVICES, INC.		3,563	3,563	17
18	V	14	PROGRAM TRANSPORTATION		REGENCY REHABILITATION SERVICES, INC.		185	185	18
19	V	19	PROFESSIONAL FEES		REGENCY REHABILITATION SERVICES, INC.		2,762	2,762	19
20	V	20	DUES AND SUBS.		REGENCY REHABILITATION SERVICES, INC.		378	378	20
21	V	21	CLERICAL		REGENCY REHABILITATION SERVICES, INC.		547	547	21
22	V	24	SEMINARS & EDUCATION		REGENCY REHABILITATION SERVICES, INC.				22
23	V	26	INSURANCE		REGENCY REHABILITATION SERVICES, INC.		471	471	23
24	V	30	DEPRECIATION		REGENCY REHABILITATION SERVICES, INC.		4,602	4,602	24
25	V	32	INTEREST EXPENSE		REGENCY REHABILITATION SERVICES, INC.		18,531	18,531	25
26	V	33	REAL ESTATE TAXES		REGENCY REHABILITATION SERVICES, INC.		6,086	6,086	26
27	V				REGENCY REHABILITATION SERVICES, INC.				27
28	V	39	THERAPY SALARY & BENEFITS		REGENCY REHABILITATION SERVICES, INC.		51,526	51,526	28
29	V								29
30	V								30
31	V	39	PHYSICAL THERAPY	40,114	REGENCY REHABILITATION SERVICES, INC.			(40,114)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 40,114			$ 90,896	$ * 50,782	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	KENNETH NEIMAN	PRESIDENT	ADMIN	33.34%	NONE	10	25.00%	MGT FEE	$ 126,563	17-7	1
2	BENJAMIN ROGOW	VICE PRESIDENT	ADMIN	33.33%	NONE	47	78.33%	MGT FEE	158,625	17-7	2
3	LOTHER KAHN	SECRETARY	ADMIN	33.33%	NONE	15	37.50%	MGT FEE	144,643	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 429,831		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: KNR PARTNERSHIP
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: ((847) 647 - 1166
Fax Number: ((847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	SQUARE FOOTAGE	6,654	4	$ 8,591	$	616	$ 795	1
2	6	REPAIRS AND MAINT.	SQUARE FOOTAGE	6,654	4	10,050		616	930	2
3	19	PROFESSIONAL FEES	SQUARE FOOTAGE	6,654	4	2,700		616	250	3
4	20	DUES AND SUBS.	SQUARE FOOTAGE	6,654	4	497		616	46	4
5	21	CLERICAL	SQUARE FOOTAGE	6,654	4	1,000		616	93	5
6	26	INSURANCE	SQUARE FOOTAGE	6,654	4	4,049		616	375	6
7	30	DEPRECIATION	SQUARE FOOTAGE	6,654	4	35,256		616	3,264	7
8	32	INTEREST EXPENSE	SQUARE FOOTAGE	6,654	4	51,522		616	4,770	8
9	33	REAL ESTATE TAXES	SQUARE FOOTAGE	6,654	4	52,343		616	4,846	9
10	33	R. ESTATE TAX-PROTEST FEE	SQUARE FOOTAGE	6,654	4			616		10
11										11
12										12
13										13
14										14
15	30	DEPRECIATION	DIRECT ALLOCATION	6,654	4	6,361			880	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 172,369	$		$ 16,249	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY MANAGEMENT CORP
Street Address: 6021 N. LAWNDALE
City / State / Zip Code: CHICAGO IL 60659
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	MNGMNT. FEE INC.	1,093,597	2	$ 4,140	$	642,281	$ 2,431	1
2	20	DUES, SUBSCRIPTIONS	MNGMNT. FEE INC.	1,093,597	2	50		642,281	29	2
3	21	CLERICAL AND GENERAL	MNGMNT. FEE INC.	1,093,597	2	862		642,281	506	3
4										4
5										5
6										6
7										7
8	17	ADMINISTRATIVE	AVG. HOURS-ROGOW	60	3	202,500	202,500	47	158,625	8
9	27	EMPLOYEE BENEFITS	AVG. HOURS-ROGOW	60	3	8,031		47	6,291	9
10										10
11	17	ADMINISTRATIVE	AVG. HOURS-KAHN	21	3	202,500	202,500	15	144,643	11
12	27	EMPLOYEE BENEFITS	AVG. HOURS-KAHN	21	3	8,031		15	5,736	12
13										13
14	17	ADMINISTRATIVE	AVG. HOURS-NEIMAN	16	3	202,500	202,500	10	126,563	14
15	27	EMPLOYEE BENEFITS	AVG. HOURS-NEIMAN	16	3	8,031		10	5,019	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 636,645	$ 607,500		$ 449,843	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY REHAB SERVICES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	THERAPY INCOME	51,382	3	$ 1,279	$	40,114	$ 999	1
2	6	REPAIRS AND MAINT.	THERAPY INCOME	51,382	3	1,596		40,114	1,246	2
3	10a	THERAPY CONSULTANTS	THERAPY INCOME	51,382	3	4,564		40,114	3,563	3
4	14	PROGRAM TRANSPORTATION	THERAPY INCOME	51,382	3	237		40,114	185	4
5	19	PROFESSIONAL FEES	THERAPY INCOME	51,382	3	3,538		40,114	2,762	5
6	20	DUES AND SUBS.	THERAPY INCOME	51,382	3	484		40,114	378	6
7	21	CLERICAL	THERAPY INCOME	51,382	3	701		40,114	547	7
8	24	SEMINARS & EDUCATION	THERAPY INCOME	51,382	3			40,114		8
9	26	INSURANCE	THERAPY INCOME	51,382	3	603		40,114	471	9
10	30	DEPRECIATION	THERAPY INCOME	51,382	3	5,895		40,114	4,602	10
11	32	INTEREST EXPENSE	THERAPY INCOME	51,382	3	23,737		40,114	18,531	11
12	33	REAL ESTATE TAXES	THERAPY INCOME	51,382	3	7,796		40,114	6,086	12
13										13
14	39	THERAPY SALARY & BENEFIT	THERAPY INCOME	51,382	3	66,000		40,114	51,526	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 116,430	$		$ 90,896	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	American National Bank		x	Line of Credit		01/01/00	$ 1,090,000	$ 600,000	01/01/02	Prime	$ 60,679	1
2	Northern Life Insurance		x	Mortgage	$64,500	03/01/95	6,000,000	4,360,291	03/01/10	10.00%	450,976	2
3	Regency Venture		x	Second Mortgage	$19,542	05/30/81	2,405,912	856,370	05/01/06	7.73%	75,485	3
4												4
5												5
	Working Capital											
6	Regency At-Home Care	x		Working Capital	None			60,594	Demand	IRS Rate	6,372	6
7	Regency At-Home Health	x		Working Capital	None			165,107	Demand	IRS Rate	1,890	7
8												8
9	TOTAL Facility Related				$84,042		$ 9,495,912	$ 6,042,362			$ 595,402	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(33,309)	10
11												11
12	Regency At-Home Care			Non-Allowed							(6,372)	12
13	Regency At-Home Health			Non-Allowed							(1,890)	13
14	TOTAL Non-Facility Related						$	$			$ (41,571)	14
15	TOTALS (line 9+line14)						$ 9,495,912	$ 6,042,362			$ 553,831	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (38,079)	1
2	Alloc-KNR Partnership	X									4,770	2
3	Alloc-Regency Rehab Services	X									18,531	3
4	Non-Allow - Regency Rehab										(18,531)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (33,309)	21

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 400,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 405,163	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,163	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 405,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 183,978 For 19 96-98 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (39,685)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 370,478	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	346,966	8
	1997	357,759	9
	1998	381,397	10
	1999	386,543	11
	2000	394,231	12

2001 Accrual = 2000 R/E tax of 394,231 x 1.035 and Rounded to 405,000

Line 2 includes an Allocation from KNR Partnership of $5061 and from Regency Rehab Services of $6358

R/E TAX REFUND ADJUSTED ON PAGE 5. RELATED TO 1998 ONLY

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REGENCY HLTHCARE & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31-401-017-0000	Long Term Care Property	$ 3,823.66	$ 3,823.66
2.	10-31-401-018-0000	Long Term Care Property	$ 86,580.58	$ 86,580.58
3.	10-31-401-019-0000	Long Term Care Property	$ 108,637.85	$ 108,637.85
4.	10-31-401-020-0000	Long Term Care Property	$ 108,637.85	$ 108,637.85
5.	10-31-401-021-0000	Long Term Care Property	$ 86,550.86	$ 86,550.86
6.	See Attached	See Attached	$ 54,677.83	$ 11,419.35
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 448,908.63	$ 405,650.15

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,591 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories FIVE

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

REGENCY AT HOME HEALTH SERVICES. LTD - HOME HEALTH AGENCY - SEPARATE BUILDING
REGENCY AT HOME CARE SERVICE, LTD. HOME HEALTH AND ADULT DAY CARE AGENCY - SEPARATE BUILDING
REGENCY REHABILITATION SERVICE LTD - REHABILITATION COMPANY - SEPARATE BUILDING

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		4/30/81	$ 450,000	1
2					2
3	TOTALS			$ 450,000	3

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1981	$ 3,708,375	$ 134,359	35	$ 123,613	$ (10,746)	$ 1,080,413	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	2,440		20	74	74	518	9
10	Various			1995	55,899		20	2,796	2,796	18,414	10
11	Various			1996	143,243		20	7,167	7,167	38,860	11
12	Various			1997	109,626		20	5,484	(5,484)	25,585	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,910,505	8,248		89,844	81,596	971,212	68
69	Financial Statement Depreciation			38,159			(38,159)		69
70	TOTAL (lines 4 thru 69)		$ 5,930,088	$ 180,766		$ 228,978	$ 37,244	$ 2,135,002	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,930,088	$ 180,766		$ 228,978	$ 48,212	$ 2,135,002	1
2	1ST FLOOR LOCKS	1998	5,121		20	256	256	981	2
3	1ST FLOOR ELECTRICAL	1998	1,789		20	89	89	341	3
4	FREIGHT ELEV REPAIR	1998	5,394		20	270	270	1,058	4
5	FREIGHT ELEV REPAIR	1998	1,300		20	65	65	255	5
6	FIRE DAMPERS	1998	6,603		20	330	330	1,238	6
7	SPRINKLER & HVAC DRA	1998	1,512		20	76	76	279	7
8	SMOKE DETECTORS	1998	920		20	46	46	169	8
9	DRIVEWAY	1998	10,000		20	500	500	1,792	9
10	BLINDS	1998	4,417		20	221	221	792	10
11	BOILER & LNDRY ELECT	1998	15,700		20	785	785	2,944	11
12	DRAPERY	1998	1,307		20	65	65	244	12
13	ELECTRICAL FEEDERS	1998			20				13
14	PATIO LIGHTING	1998	14,500		20	725	725	2,417	14
15	LAWN SPRINKLERS	1998	5,500		20	275	275	963	15
16	LANDSCAPING	1998	43,400		20	2,170	2,170	7,023	16
17	PAINTING & DECORATIN	1998	1,125		20	56	56	191	17
18	LOBBY RENOVATE	1998	7,285		20	364	364	1,183	18
19	LOBBY RENOVATIO	1998	338,164		20	16,908	16,908	53,737	19
20	HALLWAY LOCK	1998	1,378		20	69	69	230	20
21	CLOSED CIRCUIT	1998	11,560		20	578	578	1,927	21
22	NURSE CALL SYSTEM	1998	12,932		20	647	647	1,995	22
23	CC TV SYSTEM	1998	4,075		20	204	204	629	23
24	LOBBY WINDOW BLINDS	1998	548		20	27	27	83	24
25	LOBBY WALL FIXTURES	1998	3,081		20	154	154	475	25
26	LOBBY WALLPAPER	1998	4,509		20	225	225	713	26
27	LIGHTS-1ST FLOOR HAL	1998	9,750		20	488	488	1,586	27
28	WATER PIPE TO 1ST FL	1998	800		20	40	40	127	28
29	SHOWER RM LIGHTING	1998	1,500		20	75	75	238	29
30	ENTRANCE LIGHTING	1998	2,290		20	115	115	355	30
31	COFFEE NOOK LIGHTS	1998	1,000		20	50	50	154	31
32	RESIDENT ROOM LIGHTS	1998	3,530		20	177	177	546	32
33	BAROQUE LINING	1998	848		20	42	42	137	33
34	TOTAL (lines 1 thru 33)		$ 6,451,926	$ 180,766		$ 255,070	$ 74,304	$ 2,219,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,451,926	$ 180,766		$ 255,070	$ 74,304	$ 2,219,804	1
2	GENERATOR	1998	5,500		20	275	275	871	2
3	FIRE DAMPER REPAIR	1998	745		20	37	37	111	3
4	PAINT	1998	1,174		20	59	59	177	4
5	SOAP DISPENSER	1998	1,193		20	60	60	180	5
6	BLINDS	1998	359		20	18	18	54	6
7	PAINTING	1998	6,243		20	312	312	936	7
8	REMODELING FEE	1998	2,484		20	124	124	372	8
9	PERMIT FEE-LOBBY	1998	4,789		20	239	239	717	9
10	HEAT EXCHANGER TUBE	1998	1,261		20	63	63	63	10
11	HEAT EXCHANGER TUBE	1998	1,256		20	63	63	63	11
12	DOOR-HARDWARE	1999	2,830		20	142	142	426	12
13	WALL LAMPS	1999	194		20	10	10	29	13
14	LOBBY RENOVATION	1999	13,351		20	668	668	1,948	14
15	WALL LAMPS	1999	10,342		20	517	517	1,551	15
16	SIGN	1999	8,180		20	409	409	1,159	16
17	DISPENSER	1999	212		20	11	11	31	17
18	NURSE CALL SYSTEM	1999	491		20	25	25	67	18
19	CARPET	1999	600		20	30	30	83	19
20	BLINDS	1999	1,377		20	69	69	190	20
21	DRAPE	1999	169		20	8	8	22	21
22	VALVES	1999	2,518		20	126	126	347	22
23	ELEVATOR	1999	834		20	42	42	119	23
24	CONST-3 & 5 FLOOR	1999	11,200		20	560	560	1,633	24
25	FLOURESCENT FIXTURES	1999	4,200		20	210	210	543	25
26	SIGN ELECTRICAL	1999	750		20	38	38	98	26
27	TUBE BUNDLE	1999	1,257		20	63	63	189	27
28	WALLPAPER	1999	2,406		20	120	120	320	28
29	SHOWER PRESSURE VALV	1999	2,766		20	138	138	414	29
30	PLUMBING REPAIRS	1999	1,200		20	60	60	180	30
31	NATURAL GAS	1999	826		20	41	41	109	31
32	NATURAL GAS	1999	866		20	43	43	122	32
33	COMPRESSOR	1999	23,902		20	1,195	1,195	2,888	33
34	TOTAL (lines 1 thru 33)		$ 6,567,401	$ 180,766		$ 260,845	$ 80,079	$ 2,235,816	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,567,401	$ 180,766		$ 260,845	$ 80,079	$ 2,235,816	1
2	WALLPAPER	1999	2,219		20	111	111	268	2
3	WALLPAPER	1999	249		20	12	12	27	3
4	OUTLET,FIXTURE	1999	14,159		20	708	708	1,652	4
5	IMPERIAL BOOSTER	1999	3,297		20	165	165	385	5
6	FLOURESCENT FIXTURE	1999	7,700		20	385	385	834	6
7	LIMESTONE	1999	1,410		20	71	71	154	7
8	PANELS	1999	1,365		20	68	68	142	8
9	BORDERS	1999	3,029		20	151	151	340	9
10	SIGNS	1999	1,041		20	52	52	126	10
11	BATH TUB REPAIR	1999	870		20	44	44	128	11
12	REPLACE VINYL TILE	1999	1,829		20	91	91	265	12
13	PHONE SYSTEM	1999	10,922		20	546	546	1,183	13
14	ALARM SYSTEM	1999	3,888		20	194	194	404	14
15	WATER PUMP	2000	2,981		20	149	149	298	15
16	FLUORESCENT FIXTURES	2000	11,750		20	588	588	1,176	16
17	FLUORESCENT FIXTURES	2000	13,350		20	668	668	1,336	17
18	BLINDS	2000	1,500		20	75	75	138	18
19	FLAME PROOF DRAPES	2000	544		20	27	27	50	19
20	CABLE FRAMES	2000	4,979		20	249	249	477	20
21	BLINDS	2000	1,751		20	88	88	161	21
22	WALLPAPER	2000	4,422		20	221	221	424	22
23	WIRING	2000	1,015		20	51	51	94	23
24	MOTOR STARTER	2000	1,024		20	51	51	85	24
25	TIME CLOCK	2000	1,185		20	59	59	93	25
26	SUMP PUMPS	2000	4,241		20	212	212	318	26
27	CARPET METAL	2000	234		20	12	12	16	27
28	DIALYSIS CIRCUITS	2000	3,300		20	165	165	206	28
29	SOAP DISPENSER	2000	950		20	48	48	56	29
30	MISC ELECTRICAL	2000	7,200		20	360	360	420	30
31	FIRE ALARM SYSTEM	2000	520		20	26	26	41	31
32	AIR HANDLER REPAIR	2000	658		20	33	33	66	32
33	SMOKE DETECTOR	2000	650		20	33	33	41	33
34	TOTAL (lines 1 thru 33)		$ 6,681,633	$ 180,766		$ 266,558	$ 85,792	$ 2,247,220	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,681,633	$ 180,766		$ 266,558	$ 85,792	$ 2,247,220	1
2	CABLE	2000	361		20	18	18	54	2
3	CABLE & JACKS	2000	11,148		20	557	557	1,393	3
4	TELEPHONE	2000	9,900		20	495	495	825	4
5	ANTENA SYSTEM	2000	15,203		20	760	760	1,140	5
6	ELECTRICAL	2001	4,000		20	200	200	200	6
7	ELECTRICAL	2001	6,900		20	345	345	345	7
8	EMERGENCY PHONE	2001	11,500		20	575	575	575	8
9	LIGHT FIXTURES	2001	3,825		20	175	175	175	9
10	LIGHT FIXTURES	2001	3,075		20	90	90	90	10
11	ELECTRICAL	2001	4,500		20	113	113	113	11
12	LIGHT FIXTURES	2001	2,250		20	57	57	57	12
13	ELEC-4TH FLR FM RM	2001	5,000		20	146	146	146	13
14	ELEC-5TH FLR FAM RM	2001	5,000		20	125	125	125	14
15	ELECTRICAL	2001	1,906		20	48	48	48	15
16	LIGHT FIXTURES	2001	2,250		20	57	57	57	16
17	ELEC-3RD FLR FAM RM	2001	5,000		20	125	125	125	17
18	ASPHALT - PARK LOT	2001	21,917		20	548	548	548	18
19	ELEC-2ND FLR FAM RM	2001	5,000		20	104	104	104	19
20	LIGHT FIXT - 2ND FLR	2001	2,250		20	47	47	47	20
21	LIGHT FIXTURES-5TH F	2001	2,250		20	47	47	47	21
22	ELEC - 1ST FLR FAM F	2001	5,000		20	104	104	104	22
23	FLOORING	2001	1,567		20	33	33	33	23
24	INTERIOR GLASS	2001	6,982		20	116	116	116	24
25	LIGHT FIXTURES	2001	1,495		20	25	25	25	25
26	RADIO	2001	1,295		20	11	11	11	26
27	SATELLITE SYSTEM	2001	3,790		20	379	379	379	27
28	SATELITE SYSTEM	2001	4,596		20	422	422	422	28
29	ARCHITECT FEES	2001	864		20	43	43	43	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,457	$ 180,766		$ 272,323	$ 91,557	$ 2,254,567	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1994	$ 118,831	$ 3,047	39	$ 3,395	$ 348	$ 24,049	4
5				1994	149,247	3,827	39	4,264	437	30,205	5
6											6
7											7
8											8
	Improvement Type**										
9	Alloc - KNR			1994	2,421	185	20	242	57	1,715	9
10	Alloc - KNR			1995	358	32	20	36	4	251	10
11	Alloc - KNR			1995	5,490	141	20	275	134	781	11
12	Alloc - KNR			1996	1,657	166	20	83	83	1,241	12
13	Alloc - KNR			1997	97	12	20	5	(7)	67	13
14	Alloc - KNR			1999	1,833	47	20	92	45	139	14
15	Alloc - KNR			2000	3,272	39	20	67	28	39	15
16	Alloc - Regency Rehab			1994	3,040	232	20	204	(28)	2,154	16
17	Alloc - Regency Rehab			1995	450	40	20	45	5	315	17
18	Alloc - Regency Rehab			1995	6,871	176	20	344	168	977	18
19	Alloc - Regency Rehab			1996	2,072	208	20	104	(104)	1,552	19
20	Alloc - Regency Rehab			1997	121	15	20	6	(9)	83	20
21	Alloc - Regency Rehab			1999	2,292	59	20	115	56	173	21
22	Alloc - Regency Rehab			2000	1,903	22	20	39	17	22	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REGENCY BUILDING - VARIOUS	1985	$ 89,361	$	20	$ 4,468	$ 4,468	$ 75,957	37
38	REGENCY BUILDING - VARIOUS	1986	191,304		20	9,565	9,565	153,042	38
39	REGENCY BUILDING - VARIOUS	1987	285,236		20	14,262	14,262	213,928	39
40	REGENCY BUILDING - VARIOUS	1988	23,991		20	1,200	1,200	16,796	40
41	REGENCY BUILDING - VARIOUS	1989	21,445		20	1,072	1,072	13,937	41
42	REGENCY BUILDING - VARIOUS	1990	83,374		20	4,169	4,169	50,026	42
43	REGENCY BUILDING - VARIOUS	1991	68,572		20	3,429	3,429	37,717	43
44	REGENCY BUILDING - VARIOUS	1992	18,172		20	909	909	9,088	44
45	REGENCY BUILDING - VARIOUS	1993	68,257		20	3,413	3,413	30,717	45
46	REGENCY BUILDING - VARIOUS	1994	38,619		20	1,931	1,931	15,448	46
47	REGENCY BUILDING - VARIOUS	1995	502,505		20	25,125	25,125	150,750	47
48	REGENCY BUILDING - VARIOUS	1984	145,329		20	7,266	7,266	114,321	48
49	REGENCY BUILDING - VARIOUS	1983	1,868		20	93	93	643	49
50	REGENCY BUILDING - VARIOUS	1982	21,300		20	1,065	1,065	7,366	50
51	REGENCY BUILDING - VARIOUS	1981	10,524		20	526	526	3,638	51
52	REGENCY BUILDING - VARIOUS	1980	8,420		20	421	421	2,912	52
53	REGENCY BUILDING - VARIOUS	1979	32,273		20	1,614	1,614	11,163	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,910,505	$ 8,248		$ 89,844	$ 81,762	$ 971,212	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 732,998	$ 93,774	$ 44,192	$ (49,582)	10	$ 491,789	71
72	Current Year Purchases	110,544		6,168	6,168	10	6,168	72
73	Fully Depreciated Assets	485,336	499	499		10	484,901	73
74								74
75	TOTALS	$ 1,328,878	$ 94,273	$ 50,859	$ (43,414)		$ 982,858	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,609,335	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 275,039	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,182	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 48,143	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,237,425	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BUS - 1995	$ 44,625	$	$ 44,625	86
87	1996 DODGE CARAVAN - 1996	36,356	1,775	14,993	87
88					88
89					89
90					90
91	TOTALS	$ 80,981	$ 1,775	$ 59,618	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 18,774 Description: Copiers $17,086.15, Postage Machines $1,228.19, Helium Tanks $459.90
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 58,448		$ 6,935	$		$ 65,383	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			32,416			32,416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	74,497		40,398			114,895	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				171,512		171,512	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						138,865		138,865	13
14	TOTAL			$ 132,945		$ 79,749	$ 310,377		$ 523,071	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	18,715	18,715	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,087,806	2,087,806	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,654	26,654	7
8	Accounts Receivable (owners or related parties)	976,272	976,272	8
9	Other(specify): See supplemental schedule	179,226	179,226	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,288,673	$ 3,288,673	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		760,000	13
14	Buildings, at Historical Cost		5,240,000	14
15	Leasehold Improvements, at Historical Cost	1,144,292	1,144,292	15
16	Equipment, at Historical Cost	1,421,670	1,421,670	16
17	Accumulated Depreciation (book methods)	(1,413,841)	(2,219,995)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	88,327	88,327	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,240,448	$ 6,434,294	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,529,121	$ 9,722,967	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,176,033	$ 1,176,033	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	219,787	219,787	28
29	Short-Term Notes Payable	825,701	825,701	29
30	Accrued Salaries Payable	237,017	237,017	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,992	19,992	31
32	Accrued Real Estate Taxes(Sch.IX-B)	405,000	405,000	32
33	Accrued Interest Payable	36,336	36,336	33
34	Deferred Compensation	456,457	456,457	34
35	Federal and State Income Taxes	21,000	21,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	5,292	5,292	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,402,615	$ 3,402,615	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,210,269	5,216,661	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,210,269	$ 5,216,661	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,612,884	$ 8,619,276	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (83,763)	$ 1,103,691	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,529,121	$ 9,722,967	48

*(See instructions.)

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (388,786)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (388,786)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,385,023	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,080,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 305,023	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (83,763)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,491,082	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,491,082	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	492,758	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 492,758	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	875	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	190,675	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,435	19
20	Radiology and X-Ray		20
21	Other Medical Services	116,106	21
22	Laundry	3,685	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 330,776	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38,078	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 38,078	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	186,698	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 186,698	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,539,392	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,835,887	31
32	Health Care	4,008,216	32
33	General Administration	2,790,029	33
	B. Capital Expense		
34	Ownership	1,786,841	34
	C. Ancillary Expense		
35	Special Cost Centers	569,146	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,154,369	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,385,023	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,385,023	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,897	2,122	$ 76,670	$ 36.13	1
2	Assistant Director of Nursing	4,024	4,510	118,108	26.19	2
3	Registered Nurses	44,411	47,740	1,018,474	21.33	3
4	Licensed Practical Nurses	16,378	17,927	324,029	18.07	4
5	Nurse Aides & Orderlies	169,323	181,668	1,709,587	9.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,617	3,753	132,945	35.42	7
8	Rehab/Therapy Aides	7,107	7,625	72,263	9.48	8
9	Activity Director	1,333	1,566	26,355	16.83	9
10	Activity Assistants	14,370	15,464	137,983	8.92	10
11	Social Service Workers	6,222	7,242	102,830	14.20	11
12	Dietician	1,911	2,141	48,292	22.55	12
13	Food Service Supervisor					13
14	Head Cook	5,661	6,325	72,897	11.53	14
15	Cook Helpers/Assistants	36,321	39,543	283,154	7.16	15
16	Dishwashers					16
17	Maintenance Workers	4,893	5,262	93,183	17.71	17
18	Housekeepers	33,682	36,805	291,036	7.91	18
19	Laundry	16,668	18,056	117,759	6.52	19
20	Administrator	1,717	2,030	133,930	65.99	20
21	Assistant Administrator	1,952	2,169	41,470	19.12	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,424	20,404	302,258	14.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,573	1,573	46,075	29.29	33
34	TOTAL (lines 1 - 33)	391,483	423,923	$ 5,149,298 *	$ 12.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	613	$ 25,146	01-03	35
36	Medical Director	Monthly	50,600	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant	80	3,200	10-03	38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant	110	5,798	10a-03	40
41	Occupational Therapy Consultant	16	826	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,524	11-03	44
45	Social Service Consultant	Monthly	4,800	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	864	$ 98,726		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,624	$ 182,781	10-03	50
51	Licensed Practical Nurses	1,588	52,921	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	6,212	$ 235,702		53

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BARBARA HECHT	ADMINISTRATOR	NONE	$ 133,930
CAROL EATON	ASST. ADMIN.	NONE	41,470
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,400

B. Administrative - Other

Description	Amount
Regency Management Corp. - Management Fees	$ 642,281
TOTAL (agree to Schedule V, line 17, col. 3)	$ 642,281
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KBC Computer	Computer Consulting	$ 6,108
Stanley, Stanley & Kelly	Collection Service	3,480
Health Data Service	Data Processing	8,266
Accu-med	Data Processing	1,775
Medi.com	Data Processing	232
Frost, Ruttenberg & Rothblatt	Accounting	53,640
R. Peelo & Associates	Medicare Cost Report	4,800
Gates McDonald	UC Tax Rate Service	2,870
Purchase Plus	Purchasing Agent	600
See Attached		74,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 155,972

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,650
Unemployment Compensation Insurance	27,607
FICA Taxes	393,921
Employee Health Insurance	463,528
Employee Meals	48,545
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	54,397
Employee Benefits	2,834
HOLIDAY EXP	6,701
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,075,183

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,033
Health Care Worker Background Check	468
(Indicate # of checks performed 39)	
Dues and Suscriptions, License and Fees	37,152
Yellow Page Advertising	72,932
Advertising and Promotion	46,899
Alloc KNR Enterprise	46
Alloc Regency Rehab Service	29
Alloc Regency Management	378
Less: Public Relations Expense	
Non-allowable advertising	(51,600)
Yellow page advertising	(72,932)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,405

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,784
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,784

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTR # 0022418 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC - $14,880**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,208** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **48,545** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees